FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042366

Facility Name: MAPLE RIDGE CARE CENTRE

Address: 2202 N. KICKAPOO (Number) LINCOLN (City) 62656 (Zip Code)

County: LOGAN

Telephone Number: (217) 735-1538 **Fax #** (217) 735-4818

IDPA ID Number: 36-4109662

Date of Initial License for Current Owners: 11/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,770	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,601	851	5,522	11,974	8
9	SNF/PED					9
10	ICF	22,065	4,793	486	27,344	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,666	5,644	6,008	39,318	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.52%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,527

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	153,731	19,890	10,304	183,925		183,925	(824)	183,101			1
2	Food Purchase		141,634		141,634		141,634	(825)	140,809			2
3	Housekeeping	166,755	17,523		184,278		184,278	846	185,124			3
4	Laundry	15,124	13,634		28,758		28,758	214	28,972			4
5	Heat and Other Utilities			116,481	116,481		116,481		116,481			5
6	Maintenance	60,702	26,691	24,563	111,956		111,956	1,979	113,935			6
7	Other (specify):*			13,059	13,059		13,059		13,059			7
8	**TOTAL General Services**	396,312	219,372	164,407	780,091		780,091	1,390	781,481			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,283,351	92,043	45,283	1,420,677		1,420,677	(22,291)	1,398,386			10
10a	Therapy			3,302	3,302		3,302		3,302			10a
11	Activities	82,291	6,168	2,810	91,269		91,269	(806)	90,463			11
12	Social Services			2,811	2,811		2,811		2,811			12
13	Nurse Aide Training											13
14	Program Transportation			55	55		55		55			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,365,642	98,211	72,261	1,536,114		1,536,114	(23,097)	1,513,017			16
	C. General Administration											
17	Administrative	62,826		380,416	443,242		443,242	(363,475)	79,767			17
18	Directors Fees											18
19	Professional Services			218,011	218,011		218,011	(138,132)	79,879			19
20	Dues, Fees, Subscriptions & Promotions			91,750	91,750		91,750	(72,792)	18,958			20
21	Clerical & General Office Expenses	98,503	24,141	76,356	199,000		199,000	105,530	304,530			21
22	Employee Benefits & Payroll Taxes			309,253	309,253		309,253		309,253			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,293	6,293		6,293	6,607	12,900			24
25	Other Admin. Staff Transportation			9,177	9,177		9,177		9,177			25
26	Insurance-Prop.Liab.Malpractice			90,989	90,989		90,989	20,754	111,743			26
27	Other (specify):*			36,000	36,000		36,000	(36,000)				27
28	**TOTAL General Administration**	161,329	24,141	1,218,245	1,403,715		1,403,715	(477,508)	926,207			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,923,283	341,724	1,454,913	3,719,920		3,719,920	(499,215)	3,220,705			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: MAPLE RIDGE CARE CENTRE **#0042366** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,304	
	REPAIRS & MAINTENANCE		0	
			0	10,304
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		0	
	ELECTRICITY		85,293	
	WATER		29,224	
	CABLE TV - LOBBY		1,964	
			0	116,481
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,102	
	PAINTING & DECORATING		6,565	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,607	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		803	
	EXTERMINATING SERVICE		4,663	
	FIRE SERVICE		3,823	
			0	
			0	
			0	24,563
7	**OTHER**			
	SCAVENGER		12,240	
	SECURITY SERVICE		819	13,059
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000	18,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	44,083	
			0	
			0	45,283
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		2,175	
	SPEECH THERAPY SERVICES		285	
	OCCUPATIONAL THERAPY SERVICES		442	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	400	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,302
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,810	
			0	2,810
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,811	
			0	2,811
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MAPLE RIDGE CARE CENTRE #0042366 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		55	55
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	380,416	380,416
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,615	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	198,396	
			0	218,011
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	21,566	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	39,818	
	EMPLOYEE WANT ADS	XIX F	77	
	CONTRIBUTIONS	VI 20 XIX F	735	
	DUES & SUBSCRIPTIONS	XIX F	13,725	
	LICENSES & PERMITS	XIX F	3,419	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	7,261	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,063	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,086	91,750
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,899	
	EQUIPMENT REPAIR & MAINTENANCE		3,819	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,901	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		60,187	
	MESSENGER SERVICE		2,550	
			0	76,356

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	145,347	
	UNEMPLOYMENT COMPENSATION	XIX D	21,573	
	WORKERS COMPENSATION INSURANCI	XIX D	48,962	
	HOSPITALIZATION INSURANCE	XIX D	74,987	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,259	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,708	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,417	
	CHICAGO HEAD TAX	XIX D	0	309,253
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	6,144	
	TRAVEL	XIX G	149	
			0	
			0	6,293
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,177	9,177
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		90,989	90,989
27	**OTHER**			
	BAD DEBTS	VI 24	36,000	
				36,000

GRAND TOTAL COLUMN 3 OTHER 1,454,913

MAPLE RIDGE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	141,634	PATIENT MEALS	117954
LESS SALES TAX	(825)	ADD EMPLOYEE MEALS	0
NET FOOD	140,809	TOTAL MEALS/YEAR	117954
TOTAL PATIENT CENSUS	39,318	NET FOOD	140809
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	117954
TOTAL PATIENT MEALS	117954	COST PER MEAL	1.19
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MAPLE RIDGE CARE CENTRE #0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			51,681	51,681		51,681	149,575	201,256			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			193,641	193,641		193,641	190,940	384,581			32
33	Real Estate Taxes			34,604	34,604		34,604		34,604			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(516,554)	23,446			34
35	Rent-Equipment & Vehicles			24,981	24,981		24,981	6,653	31,634			35
36	Other (specify):* STORAGE			2,567	2,567		2,567		2,567			36
37	**TOTAL Ownership**			847,474	847,474		847,474	(169,386)	678,088			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,315	353,163	524,478		524,478		524,478			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		171,315	419,043	590,358		590,358		590,358			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,923,283	513,039	2,721,430	5,157,752		5,157,752	(668,601)	4,489,151			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,850)	30		9
10	Interest and Other Investment Income	(55,951)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(825)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,901)	21		18
19	Entertainment	(21,566)	20		19
20	Contributions	(4,798)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	27		24
25	Fund Raising, Advertising and Promotional	(39,818)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,261)	20		28
29	Other-Attach Schedule	(5,689)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (199,659)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(468,942)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (468,942)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (668,601)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MAPLE RIDGE CARE CENTRE

ID# 0042366

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1657	6	1
2	VACATION ACCRUAL	(824)	1	2
3	VACATION ACCRUAL	846	3	3
4	VACATION ACCRUAL	214	4	4
5	VACATION ACCRUAL	322	6	5
6	VACATION ACCRUAL	(6,161)	10	6
7	VACATION ACCRUAL	(806)	11	7
8	VACATION ACCRUAL	(937)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,689)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(824)	0	0	0	0	0	0	0	0	0	0	(824)	1
2	Food Purchase	(825)	0	0	0	0	0	0	0	0	0	0	(825)	2
3	Housekeeping	846	0	0	0	0	0	0	0	0	0	0	846	3
4	Laundry	214	0	0	0	0	0	0	0	0	0	0	214	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,979	0	0	0	0	0	0	0	0	0	0	1,979	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,390	0	0	0	0	0	0	0	0	0	0	1,390	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,161)	0	(1,830)	0	(14,300)	0	0	0	0	0	0	(22,291)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(806)	0	0	0	0	0	0	0	0	0	0	(806)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(6,967)	0	(1,830)	0	(14,300)	0	0	0	0	0	0	(23,097)	16
	C. General Administration													
17	Administrative	0	0	(178,952)	(138,392)	0	0	(46,131)	0	0	0	0	(363,475)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,681	(40,589)	25,141	395	(127,760)	0	0	0	0	0	(138,132)	19
20	Fees, Subscriptions & Promotions	(73,443)	0	365	117	12	157	0	0	0	0	0	(72,792)	20
21	Clerical & General Office Expenses	(5,838)	155	34,160	13,732	848	62,473	0	0	0	0	0	105,530	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,207	215	1,571	1,614	0	0	0	0	0	6,607	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	16,690	1,590	399	967	1,108	0	0	0	0	0	20,754	26
27	Other (specify):*	(36,000)	0	0	0	0	0	0	0	0	0	0	(36,000)	27
28	**TOTAL General Administration**	(115,281)	21,526	(180,219)	(98,788)	3,793	(62,408)	(46,131)	0	0	0	0	(477,508)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,858)	21,526	(182,049)	(98,788)	(10,507)	(62,408)	(46,131)	0	0	0	0	(499,215)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(22,850)	167,838	2,371	0	77	2,139	0	0	0	0	0	149,575	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55,951)	246,891	0	0	0	0	0	0	0	0	0	190,940	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(540,000)	10,308	0	680	12,458	0	0	0	0	0	(516,554)	34
35	Rent-Equipment & Vehicles	0	0	2,616	1,682	1,082	1,273	0	0	0	0	0	6,653	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(78,801)	(125,271)	15,295	1,682	1,839	15,870	0	0	0	0	0	(169,386)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(199,659)	(103,745)	(166,754)	(97,106)	(8,668)	(46,538)	(46,131)	0	0	0	0	(668,601)	45

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		MAPLE RIDGE, LLC		
OWNERS		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED BUSINESS		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 540,000	MAPLE RIDGE, LLC		$	$ (540,000)	1
2	V	19	ACCOUNTING FEES		" "		4,650	4,650	2
3	V	19	PROFESSIONAL FEES		" "		31	31	3
4	V	26	MORTGAGE INSURANCE		" "		16,690	16,690	4
5	V	30	DEPRECIATION - BLDG/IMP		" "		99,695	99,695	5
6	V	30	DEPRECIATION - EQPT		" "		68,143	68,143	6
7	V	32	AMORTIZATION - MTG COST		" "		3,138	3,138	7
8	V	32	INTEREST - MORTGAGE		" "		243,753	243,753	8
9	V	21	OFFICE EXPENSES		" "		155	155	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 540,000			$ 436,255	$ * (103,745)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 5,598	FHC ENTERPRISES, INC		$ 3,768	$ (1,830)	15
16	V	17	ADMINISTRATIVE	195,893	SHAEL BELLOWS OWNS 50% OF THIS FACILITY		16,941	(178,952)	16
17	V	19	PROFESSIONAL FEES	40,809	AND 100% OF FHC ENTERPRISES		220	(40,589)	17
18	V	20	DUES & SUBSCRIPTIONS		" "		365	365	18
19	V	21	CLERICAL		" "		34,160	34,160	19
20	V	24	TRAVEL		" "		3,207	3,207	20
21	V	26	INSURANCE		" "		1,590	1,590	21
22	V	30	DEPRECIATION		" "		2,371	2,371	22
23	V	34	RENT		" "		10,308	10,308	23
24	V	35	RENT - EQPT & VEH		" "		2,616	2,616	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 242,300			$ 75,546	$ * (166,754)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	YORK MANAGEMENT ASSOCIATES, INC		$ 25,141	$ 25,141	15
16	V	20	DUES & SUBSCRIPTIONS		" "		117	117	16
17	V	21	CLERICAL		" "		13,732	13,732	17
18	V	24	TRAVEL		" "		215	215	18
19	V	26	INSURANCE		" "		399	399	19
20	V	35	RENT - EQPT & VEH		" "		1,682	1,682	20
21	V	17	ADMINISTRATIVE	138,392	" "			(138,392)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 138,392			$ 41,286	$ * (97,106)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 38,264	CARLYLE NURSING ASSOCIATES, LLC		$ 23,964	$ (14,300)	15
16	V	19	PROFESSIONAL FEES		" "		395	395	16
17	V	20	DUES & SUBSCRIPTIONS		" "		12	12	17
18	V	21	CLERICAL		" "		848	848	18
19	V	24	TRAVEL		" "		1,571	1,571	19
20	V	26	INSURANCE		" "		967	967	20
21	V	30	DEPRECIATION		" "		77	77	21
22	V	34	RENT		" "		680	680	22
23	V	35	RENT - EQPT & VEH		" "		1,082	1,082	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,264			$ 29,596	$ * (8,668)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 131,037	THE KENSINGTON GROUP, LLC		$ 3,277	$ (127,760)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		157	157	16
17	V	21	CLERICAL		" "		62,473	62,473	17
18	V	24	TRAVEL		" "		1,614	1,614	18
19	V	26	INSURANCE		" "		1,108	1,108	19
20	V	30	DEPRECIATION		" "		2,139	2,139	20
21	V	34	RENT		" "		12,458	12,458	21
22	V	35	RENT - EQPT & VEH		" "		1,273	1,273	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 131,037			$ 84,499	$ * (46,538)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 46,131	CHESTERFIELD, LLC		$	$ (46,131)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 46,131			$ 0	$ * (46,131)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.95	SEE ATTACHED	0.31	2.01	SALARY	16,941	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,941		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FIRST HEALTH CARE ASSOCIATES
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (8470 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	$ 46,961	$ 46,961	19,660	$ 3,768	1
2	17	ADMINISTRATIVE	DIRECT COST	1	1	16,941	16,941	1	16,941	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739		19,660	220	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554		19,660	365	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460		19,660	7,980	5
6	21	CLERICAL	DIRECT COST	1	1	26,180	26,180	1	26,180	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971		19,660	3,207	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813		19,660	1,590	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557		19,660	2,371	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484		19,660	10,308	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	245,034	9	32,607		19,660	2,616	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 447,267	$ 90,082		$ 75,546	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: YORK MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVE DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	83,958	4	$ 107,393	$	19,658	$ 25,141	1
2	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	83,958	4	500		19,658	117	2
3	21	CLERICAL	PATIENT DAYS	83,958	4	58,659	54,452	19,658	13,732	3
4	24	TRAVEL	PATIENT DAYS	83,958	4	918		19,658	215	4
5	26	INSURANCE	PATIENT DAYS	83,958	4	1,704		19,658	399	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	83,958	4	7,184		19,658	1,682	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,358	$ 54,452		$ 41,286	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOCIATES, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	$ 285,631	$ 285,631	19,658	$ 23,964	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705		19,658	395	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142		19,658	12	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102		19,658	848	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724		19,658	1,571	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520		19,658	967	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917		19,658	77	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109		19,658	680	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	12,901		19,658	1,082	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 352,751	$ 285,631		$ 29,596	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	$ 39,055	$	19,658	$ 3,277	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	1,870		19,658	157	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,608	660,461	19,658	62,473	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234		19,658	1,614	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205		19,658	1,108	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492		19,658	2,139	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483		19,658	12,458	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176		19,658	1,273	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,007,123	$ 660,461		$ 84,499	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - MAPLE RIDGE LLC.						$	$			$	1
2	GMAC MORTGAGE COST		X	MORTGAGE		07/2002	3,715,350	3,645,208	07/2037	6.6600	243,753	2
3	LOAN COST		X	LOAN COST - AMORT 35 YRS			119,751	106,143			3,138	3
4												4
5												5
	Working Capital											
6	NOTE TO CHESTERFIELD	X		WORKING CAPITAL	DEMAND	12/04		150,043	DEMAND	VARIES	43	6
7	NOTE TO LANDMARK	X		WORKING CAPITAL	DEMAND	DEMAND	450,000	2,770,512	DEMAND	VARIES	193,598	7
8												8
9	TOTAL Facility Related						$ 4,285,101	$ 6,671,906			$ 440,532	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,285,101	$ 6,671,906			$ 440,532	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 33,972	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 34,100	2
3. Under or (over) accrual (line 2 minus line 1).		$ 128	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,476	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 34,604	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	29,063	8
2000	28,695	9
2001	29,586	10
2002	33,607	11
2003	34,100	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLE RIDGE CARE CENTRE COUNTY LOGAN

FACILITY IDPH LICENSE NUMBER 0042366

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-029-019-00	NURSING HOME	$ 34,100.08	$ 34,100.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,100.08	$ 34,100.08

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,774 B. General Construction Type: Exterior MASONRY Frame STEEL/WOOD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	170,750	1996	$ 148,352	1
2					2
3	TOTALS	170,750		$ 148,352	3

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996		$ 2,496,225	$ 90,772	27.5	$ 90,772	$	$ 745,086	4
5			1997		15,792	574	27.5	574		4,282	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - MAPLERIDGE LLC										9
10	DINING ROOM REMODELING			1997	7,441	271	27.5	271		2,019	10
11	FENCE			1997	4,300	156	27.5	156		1,165	11
12	WALLCOVERING/TILE WORK			1997	11,399	415	27.5	415		3,093	12
13	INSTALLATION OF WALLCOVERING			1997	10,590	385	27.5	385		2,872	13
14	FLOOR TILES/INSTALLATION			1997	1,160	42	27.5	42		314	14
15	OUTDOOR SIGN			1997	10,880	396	27.5	396		2,952	15
16	WALLCOVERING/TILE WORK/INSTALLATION			1998	30,545	1,111	27.5	1,111		7,174	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES			1999	31,471	1,144	27.5	1,144		6,246	17
18	OUTDOOR SIGN			1999	4,190	152	27.5	152		831	18
19	PAVEMENT			1999	6,230	227	27.5	227		1,237	19
20	REMODELING, OFFICE, ROOF CURB, DOORS			2000	22,801	829	27.5	829		3,696	20
21	WALLCOVERING, PAINTING			2000	3,683	134	27.5	134		597	21
22	PAINT & PREP ALL DOORS, BATHROOMS, KITCHEN, STORE RM			2001	13,835	503	27.5	503		1,740	22
23	EDGE VENEER COUNTER TOPS			2001	1,028	37	27.5	37		129	23
24	REMOVE & INSTALL 105 SYSTEM RUBBER ROOFING			2001	9,880	359	27.5	359		1,242	24
25	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE			2001	2,486	90	27.5	90		312	25
26	TEAR OUT AND REBUILD SECTION OF ASPHALT PRKG LOT			2002	4,477	163	27.5	163		401	26
27	EXTEND 2 WALLS TO ROOF DECK & DRYWALL COVER			2002	4,034	147	27.5	147		361	27
28	NURSING STATION - CALL LIGHT SYSTEM			2002	28,723	1,044	27.5	1,044		2,567	28
29	RUN ELECTRICITY OUT TO THE PAVILLION			2002	1,396	51	27.5	51		126	29
30	RAISE FLOORS IN 4 ROOMS, ALONG OUTSIDE WALL			2003	3,570	130	27.5	130		157	30
31	REPAIR ASPHALT - ENTIRE PARKING LOT			2003	8,545	311	27.5	311		376	31
32	INSTALL ROOFTOP UNIT			2003	6,918	252	27.5	252		304	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,741,599	$ 99,695		$ 99,695	$	$ 789,279	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 306,990	$ 28,836	$ 26,927	$ (1,909)	3-10 YRS	$ 133,621	71
72	Current Year Purchases	38,074	22,845	1,904	(20,941)	3-10 YRS	1,904	72
73	Fully Depreciated Assets	18,540					18,540	73
74	RELATED PARTIES		72,730	72,730				74
75	TOTALS	$ 363,604	$ 124,411	$ 101,561	$ (22,850)		$ 154,065	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,253,555	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 224,106	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,256	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,850)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 943,344	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	BED ADDITIONS	$ 33,846	92
93			93
94			94
95		$ 33,846	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 21,439 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 295.13	$ 3,542	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,542	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 112,810	$		$ 112,810	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			79,270			79,270	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			156,940			156,940	4
5	Physician Care	39-3	visits			1,353			1,353	5
6	Dental Care	39-3	visits			2,790			2,790	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				100,526		100,526	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY & Other (specify): RENTAL	39-2					70,789		70,789	13
14	TOTAL			$		$ 353,163	$ 171,315		$ 524,478	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 188,522	$ 608,083	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,061)	914,877	914,877	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,980	79,280	6
7	Other Prepaid Expenses	22,742	22,742	7
8	Accounts Receivable (owners or related parties)	419,362	342,569	8
9	Other(specify): ESCROW DEPOSITS		1,248,420	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,575,483	$ 3,215,972	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	995,388	995,388	11
12	Long-Term Investments	1,081	1,081	12
13	Land		585,600	13
14	Buildings, at Historical Cost		3,318,321	14
15	Leasehold Improvements, at Historical Cost		309,653	15
16	Equipment, at Historical Cost	345,064	1,208,739	16
17	Accumulated Depreciation (book methods)	(293,167)	(2,198,111)	17
18	Deferred Charges	6,183	112,326	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR. IN PROGRESS		33,846	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,054,549	$ 4,366,843	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,630,032	$ 7,582,815	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 233,431	$ 247,600	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	91,479	91,479	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,874	73,874	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,209	31,629	31
32	Accrued Real Estate Taxes(Sch.IX-B)		34,476	32
33	Accrued Interest Payable	41,734	32,630	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 450,727	$ 511,688	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,920,555	928,316	39
40	Mortgage Payable		5,879,368	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,920,555	$ 6,807,684	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,371,282	$ 7,319,372	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (741,250)	$ 263,443	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,630,032	$ 7,582,815	48

*(See instructions.)

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (362,431)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (362,427)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(353,823)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(25,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (378,823)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (741,250)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,748,244	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,748,244	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55,951	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55,951	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,804,195	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	780,091	31
32	Health Care	1,536,114	32
33	General Administration	1,403,715	33
	B. Capital Expense		
34	Ownership	847,474	34
	C. Ancillary Expense		
35	Special Cost Centers	524,478	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	266	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,158,018	40
41	**Income before Income Taxes (line 30 minus line 40)****	(353,823)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (353,823)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,242	2,480	$ 69,394	$ 27.98	1
2	Assistant Director of Nursing	1,344	1,454	34,317	23.60	2
3	Registered Nurses	2,476	2,591	62,977	24.31	3
4	Licensed Practical Nurses	30,141	32,703	537,112	16.42	4
5	Nurse Aides & Orderlies	58,380	63,114	578,395	9.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	163	234	3,008	12.85	9
10	Activity Assistants	7,808	8,541	79,283	9.28	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,751	8,321	77,894	9.36	14
15	Cook Helpers/Assistants	11,024	11,693	75,837	6.49	15
16	Dishwashers					16
17	Maintenance Workers	3,992	4,272	60,702	14.21	17
18	Housekeepers	18,092	20,013	166,755	8.33	18
19	Laundry	2,284	2,425	15,124	6.24	19
20	Administrator	2,049	2,207	62,826	28.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,911	6,350	98,503	15.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	69	92	1,156	12.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,726	166,490	$ 1,923,283 *	$ 11.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	180	$ 10,304	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	411	44,083	10-3	38
39	Pharmacist Consultant	96	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	4	400	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,810	11-3	44
45	Social Service Consultant	48	2,811	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	883	$ 79,608		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHELLE EYRSE	ADMIN		$ 62,826
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,826

B. Administrative - Other

Description		Amount
RELATED PARTIES	MANAGEMENT FEES	$ 380,416
TOTAL (agree to Schedule V, line 17, col. 3)		$ 380,416
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		218,011
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 218,011

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 48,962
Unemployment Compensation Insurance		21,573
FICA Taxes		145,347
Employee Health Insurance		74,987
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		13,259
EMPLOYEE PHYSICAL EXAMS		2,708
PENSION/PROFIT SHARING PLANS		2,417
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 309,253

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	77
Health Care Worker Background Check	1,086
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	68,645
TRUST/FRANCHISE/CONTRIB/ETC	4,798
LICENSES & PERMITS	3,419
DUES & SUBSCRIPTIONS	13,725
MGMT CO ALLOCATION	651
TRUST/FRANCHISE/CONTRIB/ETC	(4,798)
Less: Public Relations Expense	(21,566)
Non-allowable advertising	(39,818)
Yellow page advertising	(7,261)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,958

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	149
RELATED PARTY	6,607
Seminar Expense	
	6,144
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,900

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	06/2001	$ 3,199	3	$ 533	$ 1,066	$ 1,066	$ 534	$	$	$	$	$
2	PAINTING/DECORATIN	06/2002	12,265	3		2,044	4,088	4,088	2,045				
3	PAINTING/DECORATIN	06/2003	7,519	3			1,253	2,506	2,506	1,254			
4	PAINTING/DECORATIN	06/2044	6,565	3				1,094	2,188	2,188	1,095		
5													
6													
7													
8													
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18													
19													
20	TOTALS		$ 29,548		$ 533	$ 3,110	$ 6,407	$ 8,222	$ 6,739	$ 3,442	$ 1,095	$	$

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. HEALTHCARE ASSOC. -$7056**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **657** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees